ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Texas Family Eyecare and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Texas Family Eyecare of any changes in my health care coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Texas Family Eyecare and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Texas Family Eyecare for all covered medical services and supplies provided to me during all courses of treatment and care provided by Texas Family Eyecare and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Texas Family Eyecare and will constitute a continuing authorization, maintained on file with Texas Family Eyecare, which will authorize and allow for direct payment to Texas Family Eyecare of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Texas Family Eyecare.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Texas Family Eyecare. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Texas Family Eyecare.

_____ _____ _____

Patient/Insured (Printed Name) Date of Birth Social Security Number

_____ _____

Patient/Insured (Signature) Date of Signature

_____ _____

Witness (Signature) Date of Signature

HIPAA Notification

I, _____, have been presented with the Notice of Privacy Policy of Texas Family Eyecare and have been offered a copy of such policy.

_____ _____

Patient/Guardian Signature Date of Signature